MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SPECIAL HEALTH CARE NEEDS

ADULT HEAD INJURY PROGRAM PRIOR AUTHORIZATION

CLIENT NAME (LAST, FIRST, MI)	DATE OF BIRTH	AGE	DCN

ADDRESS (STREET, CITY, STATE, ZIP)	COUNTY

PROVIDER NAME	TELEPHONE NUMBER

ADDRESS	CONTACT PERSON

SERVICES REQUESTED

- Individualized service or treatment plan/progress report must be submitted with request. Plan must include goal or objectives and assurance that client/family participated in planning, and agree with the plan.

Cognitive/Behavioral
- ☐ 0005 - Neuropsychological Eval/ Consultation
- ☐ 0006 - Behavioral Assessment/Consultation

Adjustment Counseling - Individual
- ☐ 0010 - Psychologist
- ☐ 0011 - Social Work
- ☐ 0012 - LPC

Adjustment Counseling - Group
- ☐ 0013 - Psychologist
- ☐ 0014 - Social Work
- ☐ 0015 - LPC

Community Integration
- ☐ 0004 - Transitional Home and Community Support
- ☐ 0138 - Socialization Skills Trng (3 hr half day)

Educational/Vocational
- ☐ 108 - Pre-Voc/Pre-Emp Trng (3 hr half day)
- ☐ 0008 - Pre-Voc/Pre-Emp Trng (6 hr)
- ☐ 0009 - Supported Emp-Long Term Follow-Up
- ☐ 0007- Special Instruction

Transportation
- ☐ 0026 - Individual
- ☐ 0027- Group Same Location
- ☐ 0028 - Group Different Locations

DATES OF SERVICE REQUESTED	NUMBER OF UNITS / WK	LIST MONTH AND NUMBER OF UNITS			TOTAL UNITS REQUESTED

FOR STATE USE ONLY

SERVICE COORDINATOR ONLY

DATE RECEIVED

Participant on Waiting List? ☐ Yes ☐ No

Does any other payer cover requested services? ☐ Yes ☐ No
(If yes, written denial must be attached)

Primary Outcome Goal
☐ Ed/Voc ☐ Ind. Liv. ☐ Comm. Part

Is requested service essential to outcome goal? ☐ Yes ☐ No

RECOMMENDATION
☐ Approved ☐ Denied
☐ Modify _____
(SUGGESTED CHANGE)

SERVICE COORDINATOR'S SIGNATURE
➔

PROGRAM MANAGER ONLY
☐ Approved ☐ Denied

DATES OF APPROVAL
to

Comments:

MONTH	UNITS	UNIT COST	MO/COST
		TOTAL COST	$

PROGRAM MANAGER'S SIGNATURE
➔

UPON COMPLETION - INITIAL AND DATE	MOHSAIC Entry	Sent to Provider	Sent to S.C.

TRANSPORTATION INFORMATION

- This section must be completed for transportation costs to be reimbursed.
- Transportation reimbursement is limited to one round trip to/from rehabilitation program per day.

RELATED DHSS ADULT HEAD INJURY PROGRAM SERVICE
☐ Prevocational Training
☐ Socialization Skills Training

REQUEST IS FOR (CHECK ONE) ☐ Individual ☐ Group Transportation

COMPLETE ONLY ONE CATEGORY BELOW

INDIVIDUAL

Mileage one way _____
x 2 _____

TOTAL MILEAGE FOR ROUND TRIP [ ]

GROUP – SAME LOCATION

Names of DHSS Clients Transported to Adult Head Injury Program Service:
(Copy and add additional sheets if necessary.)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

MILEAGE BETWEEN CLIENT PICK UP POINTS

MILEAGE ONE WAY _____
x 2 _____

TOTAL ROUND TRIP MILEAGE [ ]

GROUP – DIFFERENT LOCATION

Names of DHSS Clients Transported to Adult Head Injury Program Service:
(Copy and add additional sheets if necessary.)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

MILEAGE BETWEEN CLIENT PICK UP POINTS

To Client 1 _____
Client 1 - Client 2 _____
Client 2 - Client 3 _____
Client 3 - Client 4 _____
Client 4 - Client 5 _____
Client 5 - Client 6 _____

MILEAGE ONE WAY _____
x 2 _____

TOTAL ROUND TRIP MILEAGE [ ]